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International Covenant on Civil and Political Rights

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Human Rights Committee

Decision adopted by the Committee under the Optional Protocol, concerning communication No. 2296/2013*, **

Communication submitted by:	S.C. (represented by counsel, Anna Brown, of the Human Rights Law Centre)
Alleged victims:	The author and T.J.C.
State party:	Australia
Date of communication:	3 September 2013 (initial submission)
Document references:	Decision taken pursuant to rule 97 of the Committee's rules of procedure, transmitted to the State party on 29 October 2013 (not issued in document form)
Date of adoption of decision:	2 November 2018
Subject matter:	Effectiveness and independence of investigation into fatal shooting of a minor by the police
Procedural issues:	Exhaustion of domestic remedies; level of substantiation of claims
Substantive issues:	Right to life; right to access to justice; right to an effective remedy
Articles of the Covenant:	2 (3), 6 (1) and 14
Articles of the Optional Protocol:	2 and 5 (2) (b)

1. The author of the communication is S.C., a national of Australia. She submits the communication on her own behalf and on behalf of her deceased son, T.J.C., born on 20 April 1993. She claims that the State party failed to ensure an effective and independent investigation into the death of her son in violation of her and her son's rights under article 6 (1), read alone and in conjunction with article 2 (3), and that the State party has violated her rights under article 14, of the Covenant. The Optional Protocol entered into force for the State party on 25 December 1991. The author is represented by counsel.

* Adopted by the Committee at its 124th session (8 October–2 November 2018).

** The following members of the Committee participated in the examination of the communication: Tania Maria Abdo Rocholl, Yadh Ben Achour, Ilze Brands Kehris, Sarah Cleveland, Ahmed Amin Fathalla, Olivier de Frouville, Christof Heyns, Bamariam Koita, Marcia V.J. Kran, Duncan Laki Muhumuza, Photini Pazartzis, Mauro Politi, José Manuel Santos Pais, Yuval Shany, Margo Waterval and Andreas Zimmermann.

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The facts as submitted by the author

2.1 On the evening of 11 December 2008, the author's 15-year-old son was fatally shot by members of Victoria Police at All Nations Park, Northcote, Victoria. The circumstances of the shooting have been established by an inquest conducted by the Coroners Court of Victoria. About 11 minutes before the shooting, the author's son armed himself with two large knives he had stolen from a store inside a shopping centre, adjacent to All Nations Park. He then moved through the shopping centre and the adjoining shops and car park, pointing the knives at people and demanding that the police be called or people would die that night. At least four people contacted the emergency services to advise the police of the presence of a male who was armed with knives and threatening people.

2.2 Four police officers arrived at the scene and requested the author's son to drop the knives. However, he did not do so. The police officers then used oleoresin capsicum foam spray on him. Refusing to obey the orders to drop the knives, the author's son advanced on the police officers. During the investigation into the incident, the police officers stated that they had ordered the author's son to put down the knives and stop approaching them, or he would be shot. They backed away as he advanced, before firing a warning shot. One of the police officers became isolated from the other three. The officer stated that, fearing for his life, having been backed up against a railing and having exhausted all other non-lethal options, he had fired three shots directly at the author's son's chest area as the author's son had walked towards him. Several other shots were fired in rapid succession at this time. In total, 10 shots were fired by three of the four police officers present, with five shots directly hitting the author's son, one of them fatally entering his body below his left clavicle and causing significant internal bleeding and the collapse of his right lung. He died within minutes at the scene.

2.3 The author provides information on investigative bodies in Victoria that deal with deaths associated with police contact. It is common practice for the Victoria Police Homicide Squad, the Ethical Standards Department of Victoria Police and the State Coroner's Office to be notified in the first instance and attend the scene. At the time of the incident, the Office of Police Integrity had a general responsibility in relation to police misconduct and ethical and professional standards, but no specific role to play in the investigation of deaths associated with police contact. The Homicide Squad conducts the primary investigation into deaths associated with police contact. That squad is a unit within Victoria Police. It prepares and delivers to the coroner an "inquest brief" on the basis of the primary investigation. That brief of evidence forms the basis of the subsequent coronial inquiry. The Ethical Standards Department of Victoria Police oversees the investigation of deaths or incidents causing serious injury that are associated with police contact. The intended role of the Department is to ensure that there is no impediment to the investigation, and that the integrity of the investigation is maintained through active oversight.

2.4 At the time of the author's son's death, the Office of Police Integrity was empowered to conduct an "own motion" investigation into any matter relevant to the achievement of its Director's objectives, including objectives that arose in respect of deaths associated with police contact. The Office could conduct an investigation in parallel with that conducted by Victoria Police, or it could conduct its own investigation into any aspect of a death. However, it had no authority to investigate a death associated with police contact without the involvement of, or instead of, Victoria Police. The oversight functions of the Office have since been transferred to the Independent Broad-based Anti-corruption Commission.[1] In common with the Office, the Commission has a general responsibility in relation to police misconduct, but no specific role to play in the investigation of deaths associated with police contact.

2.5 The State Coroner has a statutory obligation to investigate deaths occurring in a range of circumstances. A coroner investigating a death must establish, if possible: (a) the identity of the deceased; (b) the cause of death; (c) the circumstances in which the death occurred; and (d) any other prescribed particulars. A coroner may report to the Attorney-

[1] With the establishment of the Commission on 11 February 2013, the Office of Police Integrity was dissolved.

General on a death that he or she has investigated, and may make recommendations to any minister, public statutory authority or entity on any matter connected with a death, including recommendations relating to public health and safety or the administration of justice.

2.6 The author refers to the Committee's concluding observations on the fifth periodic report of the State party, in which the Committee expressed concern at reports of excessive use of force by law enforcement officials against groups, such as indigenous people, racial minorities, persons with disabilities and young people, and regretted that investigations into allegations of police misconduct were carried out by the police itself.[2]

2.7 Following the shooting, police officers called the Emergency Services Telecommunications Authority at 9.31 p.m. A total of 73 seconds elapsed between the time the police officers first saw and engaged with the author's son and the moment they called an ambulance. The Ethical Standards Department was notified of the fatal shooting at 9.55 p.m. The major crime desk was notified at 10.32 p.m., and subsequently contacted the Victoria Police Homicide Squad at 10.38 p.m. At 10.40 p.m., a member of Victoria Police contacted the Coroners Court. At 11.36 p.m., members of the Homicide Squad commenced the primary investigation at the scene of the shooting, under the oversight of the Ethical Standards Department. Throughout the evening of 11 December 2008 and the morning of 12 December 2008, members of Victoria Police were present at the scene of the shooting.

2.8 The coroner attended a debriefing conducted by Victoria Police on the night of the shooting, and subsequently had no further involvement in the investigation prior to the delivery of the inquest brief to the Coroners Court in September 2009. A media statement leaning towards justifying the use of force by the police officers was authorized by Victoria Police and released a few hours after the author's son's death. This was done in breach of the policy regarding media interaction following a critical incident, as the police failed to seek the coroner's approval prior to releasing the statement. Furthermore, despite the fact that police officers represented to the author and her family that they would not release the author's son's name without consultation with them, early on the morning of 12 December 2008 his name was put into the public domain, followed by a significant quantity of personal information about him. The coroner found that there was no evidence as to how his name had got into the public domain.

2.9 In a letter addressed to the coroner and dated 23 April 2009, the author requested that the responsibility for conducting the investigation into her son's death be transferred from Victoria Police to the Office of Police Integrity. On 5 May 2009, the Office declined the coroner's request that it take over the investigation on the grounds that it did not have the resources or necessary charter to do so. However, the Director of the Office subsequently authorized an assessment of the adequacy of the police investigation into the author's son's death, which was conducted between May 2009 and March 2010. The content of the resulting report is confidential. The Office also conducted a separate inquiry into the way in which deaths associated with police contact are investigated in Victoria and issued a public report in June 2011, stating that the current legislative framework for the investigation and oversight of deaths associated with police contact was not optimal. The Office made a series of recommendations regarding improvements to the model whereby Victoria Police is responsible for investigations, but noted that it was ultimately a matter for the Government of the State of Victoria to determine whether any policy or legislative changes were appropriate.

2.10 On 30 September 2009, the Homicide Squad delivered to the Coroners Court an inquest brief on the basis of the primary investigation it had conducted. The brief formed the basis of the subsequent coronial inquiry. On 23 November 2011, the coroner issued an inquest finding. She held that the police had fired at the author's son at a moment when a police officer was in immediate and perilous danger of serious injury or death. She further found that there were some deficiencies in the investigation conducted by the Homicide Squad.[3]

[2] CCPR/C/AUS/CO/5, para. 21.

[3] See paragraph 4.14.

The complaint

3.1 The author notes that she does not request that the Committee determine whether the State party breached its substantive obligations under article 6 (1) of the Covenant. Rather, she submits that the potential breach of the substantive obligations that resulted from the circumstances of her son's death obliged the State party to investigate his death in accordance with its obligations under the Covenant. It is the State party's failure to fulfil this duty to investigate that is the subject of the communication.

3.2 The author submits that the current model in Victoria for investigating deaths associated with police contact is inconsistent with the State party's obligations under the Covenant. She argues that the State party failed to ensure an effective and independent investigation into the death of her son in violation of her and her son's rights under article 6 (1), read alone and in conjunction with article 2 (3), and in violation of her rights under article 14 of the Covenant.

3.3 The author refers to the Committee's jurisprudence and notes that where individuals have been killed as a result of the use of force by State agents, the State party is required to ensure that there is an impartial, effective and timely investigation into the death.[4] She argues that in order to meet this requirement, the investigation must: be hierarchically, institutionally and practically independent;[5] be adequate and effective;[6] be open to public scrutiny;[7] be prompt and carried out with reasonable expedition;[8] and involve the next of kin.[9] The author submits that the investigation, comprising the primary investigation conducted by Victoria Police and the subsequent coronial inquiry, did not meet these requirements, resulting in a violation of her son's rights under article 6 (1) of the Covenant.

3.4 The author submits that the independence of the investigation was compromised because the primary investigation was not conducted by a formally independent body and was not carried out with genuine independence. The process was not institutionally independent because the Homicide Squad had primary responsibility for conducting the investigation into the death. Since the Homicide Squad is a unit within Victoria Police, those conducting the primary investigation belonged to the same body as the officers being investigated. Nor was the investigation practically independent. It is not sufficient for an independent body to oversee an investigation carried out by investigators organizationally connected with those under investigation.[10] The author argues that, for this reason, the oversight provided by the Ethical Standards Department, the Office of Police Integrity and the inquest were not sufficient to ensure the independence of the investigation. The lack of cultural independence is also likely to have impacted the effectiveness of the investigation because of the possibility that the investigators' objectivity and assessment may have been affected. As a result of the organizational connection between the investigators and those under investigation, the primary investigation was not culturally independent.

3.5 The author further submits that the coronial investigation into her son's death was not adequate and effective because coroners in the State of Victoria generally lack the

[4] The author refers, inter alia, to *Pestaño v. Philippines* (CCPR/C/98/D/1619/2007); and *Zhumbaeva v. Kyrgyzstan* (CCPR/C/102/1756/2008). She also refers to European Court of Human Rights, *Fedorchenko and Lozenko v. Ukraine* (application No. 387/03), judgment of 20 December 2012; *McCann and others v. United Kingdom* (application No. 18984/91), judgment of 27 September 1995; *Dodov v. Bulgaria* (application No. 59548/00), judgment of 17 January 2008; and *Vo v. France* (application No. 53924/00), judgment of 8 July 2004.

[5] The author refers to *Eshonov v. Uzbekistan* (CCPR/C/99/D/1225/2003); *Pestaño v. Philippines*; and, inter alia, to European Court of Human Rights, *Fedorchenko and Lozenko v. Ukraine*; *Hugh Jordan v. United Kingdom* (application No. 24746/94), judgment of 4 August 2001; and *Al-Skeini and others v. United Kingdom* (application No. 55721/07), judgment of 7 July 2011.

[6] *Pestaño v. Philippines*; *Amirov v. Russian Federation* (CCPR/C/95/D/1447/2006); *Fedorchenko and Lozenko v. Ukraine*; and, inter alia, European Court of Human Rights, *Şimşek and others v. Turkey* (applications Nos. 35072/97 and 37194/97), judgment of 26 October 2005; *Hugh Jordan v. United Kingdom*; and *Al-Skeini and others v. United Kingdom*.

[7] *McCann and others v. United Kingdom*; and *Al-Skeini and others v. United Kingdom*.

[8] *Pestaño v. Philippines*.

[9] *Fedorchenko and Lozenko v. Ukraine*.

[10] *Hugh Jordan v. United Kingdom*.

ability to control the quality of the primary investigation,[11] and there were deficiencies in the primary investigation that undermined the effectiveness of the coronial investigation and inquest into her son's death. She notes that the primary investigation included several noted deficiencies, and submits that where deficiencies such as these are associated with an investigation, legitimate doubts will be raised as to the overall integrity of the investigative process.[12]

3.6 The author also argues that certain aspects of the investigation call into question whether the investigation was sufficiently open to public scrutiny. She notes that conducting coronial inquests in open court will generally satisfy this obligation, but also notes that the Homicide Squad failed to inform the coroner of the covert recordings made of conversations that members had held with the author and her family.

3.7 The author submits that there were delays in the investigation into her son's death that give rise to legitimate concerns about the promptness of the investigation. In this respect, she notes that: the Homicide Squad was not notified of her son's death until over an hour after it had occurred; the police officers present at the shooting were not tested for drugs or alcohol until after 6 a.m. on 12 December 2008, which impaired the test results and which the coroner found unsatisfactory; testing for gunshot residue was not undertaken until sometime after 1 a.m. on 12 December 2008; the Homicide Squad did not focus on identifying potential witnesses and delayed canvassing the incident area until May 2010; the inquest brief was not provided to the coroner until 30 September 2009; the inquest commenced on 19 October 2010; and the inquest finding was issued on 23 November 2011.

3.8 The author submits that the nature of her and other members of her family's involvement in the investigation is inconsistent with procedural obligations regarding the involvement of the next of kin under article 6 (1) of the Covenant. Namely, the Homicide Squad made covert recordings of conversations they had conducted with the author and her family; a media statement regarding her son's death was released at around 1 a.m. on 12 December 2008, just a few hours after his death; her son's name was put into the public domain without consultation with the family; the victim's brother was restrained by the police when he attempted to enter the scene of his brother's death; the author was separated from her partner and the victim's brother prior to her son's death being reported; and on the night of her son's death, the author, her partner and the victim's brother were requested to attend Preston Police Station to make statements, without legal or welfare support.

3.9 The author submits that the breach of the procedural obligations associated with the right to life resulted in her inability to access justice throughout the investigation and the inquest. She notes that article 14 of the Covenant has been considered by the Committee in circumstances where the death of a civilian was allegedly related to the conduct of State agents.[13] She argues that the State party's failure to provide an independent and impartial investigation into the death of her son meant that the subsequent inquest was not sufficiently independent or impartial. She submits that, accordingly, her right to a fair and public hearing relating to her son's death was not effectively guaranteed, in violation of her rights under article 14.

3.10 The author argues that the State party has also failed to ensure an effective remedy under article 2 (3) of the Covenant for the breach of her son's right to have his death investigated in accordance with the procedural obligations of article 6 (1). She further argues that this constitutes a breach of her right to access to justice in violation of article 2 (3), read in conjunction with article 6 (1). The author submits that, if the Committee finds that the State party has breached article 6 (1) of the Covenant in respect of the investigation into the death of her son, it has also breached its obligations under article 2 (3).

3.11 The author requests the Committee to recommend that the State party: enact legislation and develop appropriate policies, processes, institutions and mechanisms to

[11] The author notes that in 2005, Victoria Police stated in connection with the review of the Coroners Act 1985 that coroners did not have the power to issue directions directly to investigating police.

[12] European Court of Human Rights, *McKerr v. United Kingdom* (application No. 28883/95), judgment of 4 May 2001.

[13] *Kholodov v. Russian Federation* (CCPR/C/106/D/1548/2007).

ensure independent and effective investigation into all deaths associated with police contact in accordance with the requirements of article 6 (1); and issue a public apology and reparations to the author for its failure to ensure an effective and independent investigation into her son's death.

State party's observations on admissibility and the merits

4.1 On 17 November 2014, the State party submitted its observations on the admissibility and the merits of the communication. It acknowledges the tragic circumstances of the author's son's death and expresses its sympathy to the author and her family, but submits that the communication should be declared inadmissible for failure to exhaust domestic remedies, pursuant to article 5 (2) (b) of the Optional Protocol, and for failure to substantiate the claims for the purposes of admissibility, pursuant to article 2 of the Optional Protocol. In the alternative, should the Committee find the communication to be admissible, the State party submits that the complaint is without merit.

4.2 The State party submits that the communication is inadmissible for failure to exhaust domestic remedies by: (a) appealing the inquest finding, seeking a new inquest and seeking judicial review; (b) commencing a claim against the State of Victoria, the coroner or Victoria Police; and (c) filing a complaint before the Independent Broad-based Anti-corruption Commission.

4.3 The State party submits that the author can appeal against the coroner's findings resulting from the inquest into her son's death and seek a new inquest. The Coroners Act 2008 provides for the appeal of decisions of the Coroners Court of Victoria to the Supreme Court of Victoria when it comes to questions of law. The Act contains appeal provisions in relation to the findings of a coroner. These relate to the mandatory matters that a coroner must establish, that is, the identity of the deceased, the cause of death and the circumstances in which the death occurred. The Supreme Court may issue any order that it considers appropriate, including individual relief or remedy in the nature of certiorari, mandamus, prohibition or quo warranto. The Supreme Court may also remit the matter for rehearing. The State party argues that the author could appeal against the coroner's findings and seek a new inquest on the grounds that: the findings were not open on the evidence; there was a failure to accord natural justice; or there was an insufficient inquiry.

4.4 The State party notes that the author could not appeal an error of fact in the inquest, as it is not the function of the Supreme Court to conduct a merits review of a coroner's decision. However, there are grounds for challenging factual findings where the coroner's primary findings of fact were not open on the evidence before the coroner. If the author could establish that there was no evidence to justify certain findings made by the coroner in relation to the adequacy of the primary investigation, such an appeal may have a reasonable chance of success. A fact-finding error, in certain circumstances, can also provide grounds for judicial review. The author could appeal on a question of law that the coroner's findings were tainted by an incorrect finding of a jurisdictional fact. The author could also appeal the findings on the grounds that there has been a failure to accord natural justice. A relevant principle of natural justice requires the coroner to conduct the inquest so that there would not be a reasonable apprehension that the coroner might not bring an impartial and unprejudiced mind to the resolution of the question. Accordingly, the author may have a basis for seeking review of the coronial findings in circumstances where the inquiry is said to be insufficiently independent and impartial. Additionally, it may be held that there has been an insufficient inquiry if a coroner fails to deal with fundamental issues concerning the statutory obligations relating to the findings. Accordingly, as the author appears to be of the view that the coroner failed to deal with the competency, adequacy and impartiality of the police investigation, it may be available to her to pursue a claim on the grounds that there has been an insufficient inquiry.

4.5 The State party does not accept the author's submission that a new inquest would not offer a reasonable prospect of success. The coroner has extensive powers of investigation when a new hearing is held, which are not limited to relying on any existing evidence, including that gathered by Victoria Police. The coroner can conduct further inquiries and exercise powers to gather evidence, compel documents and summon

witnesses. Furthermore, the Coroners Act 2008 enables the Court to refer matters to prosecutorial bodies to consider whether criminal proceedings should be instituted.

4.6 The State party argues that the author has not exhausted domestic remedies, as she has failed to pursue a civil or criminal prosecution. The author may seek damages for wrongful death or common-law negligence. A civil action could enable the author to obtain redress for any alleged wrongdoing associated with her son's death. The Victorian criminal justice system also provides a mechanism to prosecute murder and manslaughter, or offences in relation to any alleged improprieties of the investigation. Criminal prosecution can be initiated by private citizens.

4.7 The State party notes the Committee's jurisprudence in *Jonassen et al. v. Norway*,[14] according to which an author must make use of not only all judicial, but also all administrative remedies that offer a reasonable prospect of redress. It submits that one such remedy available to the author is to make a complaint to the Independent Broad-based Anti-corruption Commission. It notes the author's claim that the Commission only has the power to report and make non-binding recommendations and non-mandatory requests for action. It argues that, on the contrary, the Commission has broad jurisdiction to investigate police conduct. It has the capacity to conduct its "own motion" investigation into various aspects of deaths associated with police contact or following a complaint. It may undertake a range of separate investigative actions, including an independent investigation into all aspects of a police contact-related death. Its referral powers enable it to refer matters to prosecutorial bodies to consider whether or not to institute criminal proceedings. It can also initiate criminal proceedings as a prosecutorial body in its own right in relation to any matter arising out of an investigation.

4.8 The State party also submits that the communication should be found inadmissible because the author has failed to substantiate her claims that the investigation into her son's death was not independent or effective and that her and her son's right to an effective remedy was breached.

4.9 As to the merits of the communication, the State party notes that the author claims that it violated its obligation under article 6 (1) of the Covenant by failing to ensure an effective and independent investigation into her son's death. It submits that the Committee should follow its previous practice of not exhaustively articulating the duty to investigate. It contends that it is not possible to formulate a single model for investigating deaths, as the investigation will depend on the legal system in place in each State. It submits that the adequacy of an investigation should be assessed on a case-by-case basis. It notes that there is no other body external to Victoria Police with appropriate skills or expertise to conduct these kinds of investigations in Victoria.

4.10 The State party submits that the coronial investigation into the author's son's death was a functionally separate, independent and effective investigation. It disputes the author's claims that the role played by the Homicide Squad was deficient, and that the coroner relied solely on the inquest brief prepared by Victoria Police or was empowered to rely solely on this. The coroner is an independent judicial officer who is in charge of, and directs, all coronial investigations. The inquest into the author's son's death was not a separate investigation by the coroner after an initial investigation by the Homicide Squad investigator. Rather, the inquest was part of the coroner's continued investigation into the author's son's death, which commenced when the death was reported to the coroner on the night of the incident. The State party submits that in Victoria, the combination of coronial control and direction, police expertise and the oversight of an independent agency such as the Office of Police Integrity is the most effective means of determining what occurred in a fatal incident. The inquest brief prepared by the coroner's police investigator represents only the record of evidence gathered by the police officer. The coroner does not regard it as either definitive or final in terms of the extent of investigations required.

4.11 The State coroner conducted the coronial investigation into the incident. The State coroner presides over the Coroners Court of Victoria. That court is a specialist inquisitorial court comprising independent judicial officers responsible for investigating deaths and

[14] *Jonassen et al. v. Norway* (CCPR/C/76/D/942/2000).

making recommendations for the prevention of deaths. In Victoria, all police shooting deaths are investigated by way of coronial investigation, which includes a mandatory public inquest. The coroner was assisted in her investigation by an independent counsel (a barrister) from the Victorian Bar and solicitors from a legal firm. The Victorian Institute of Forensic Medicine and the Victoria Police Homicide Squad produced and gathered evidence for and on behalf of the coroner. A detective from the Homicide Squad was nominated as the coroner's investigator to gather evidence for and on behalf of the coroner, with full access to the investigative resources of Victoria Police. The coroner's investigator and the Victorian Institute of Forensic Medicine can be directed, at the coroner's discretion, to pursue particular lines of inquiry, timing and approaches. At the discretion of the coroner, information, reports and witness statements prepared by the coroner's investigator and the Victorian Institute of Forensic Medicine formed part of the inquest brief.

4.12 The Ethical Standards Department and the Office of Police Integrity exercised oversight and integrity functions relating to the conduct of the coroner's investigator. The Department oversaw the Homicide Squad officers conducting the investigation, ensuring that the investigation was undertaken impartially. The Department oversight file was provided to the coroner, who determined that the file should form part of the evidence at the inquest. The Office of Police Integrity oversaw the police investigation and the exercise of the functions of the Ethical Standards Department, and was hierarchically, institutionally and practically independent of Victoria Police. The Office reviewed the Homicide Squad's investigation to inform the coronial process. That review provided an independent expert opinion on the sufficiency of the police investigation and the coroner decided that it would be admitted into evidence at the inquest.

4.13 The coroner was in charge of and had ongoing involvement in the investigation into the author's son's death. The scope of the inquest was broad and included efforts to look into the circumstances of the death, whether the use of force was justified and whether anything could be done to avoid such a situation in the future. The coroner also critically examined the process of gathering evidence for a coronial investigation. This line of inquiry addressed issues of competency, adequacy and impartiality in relation to how evidence was collected, obtained or potentially compromised, and the practices that supported the coronial process itself. The coroner conducted the inquest into the death of the author's son over 41 days of public hearings held between 19 October 2010 and 11 March 2011. The family exercised their right to be involved in the coronial investigation as interested parties. They were represented by legal counsel at the inquest. The coroner considered a broad range of evidence at the inquest. The final inquest brief was in excess of 3,670 pages and included approximately 115 witness statements, 121 exhibits and statements from the police officers involved in the shooting. The officers also gave oral testimony at the inquest and were subjected to questioning and cross-examination by the coroner, the family members and other interested parties. On 23 November 2011, the coroner published her findings, which held that the police had fired at the author's son at a moment when a police officer was "in immediate and perilous danger of serious injury or death". The coroner found no evidence of an actual conflict of interest in the police investigation. She made eight recommendations for changes to the broader investigatory system in Victoria.

4.14 The State party further notes that the coroner addressed the alleged deficiencies in the investigation noted by the author. The reported one-hour delay in contacting the Homicide Squad about the incident was due to uncertainty as to who was responsible for notifying the squad. However, according to the inquest findings, it did not have an impact on the probity of the investigation. The coroner further found that there was no evidence to suggest that the failure to conduct drug and alcohol testing of the police officers involved in the shooting in a timely manner was a result of anything other than a lack of knowledge of proper procedure. She also found that there was no evidence to indicate that any of the officers was affected by alcohol or drugs. Furthermore, the coroner did not find the investigation lacking in probity as a consequence of the delay in undertaking gunshot residue testing, as this would not have added anything to the investigation, given that it was not unclear whether or not shots had been fired or who had fired them. The State party *disputes the author's claim that* witnesses were not identified in a timely manner, noting that at least 29 witness statements tendered at the inquest were obtained within 24 hours of the incident, while 65 witness statements were obtained in all. The State party further notes

that many of the other deficiencies alleged by the author were also considered by the coroner, who found no evidence to indicate that the alleged deficiencies had compromised the effectiveness of the coronial investigation. The State party notes that it was the coronial process itself that revealed some of the regrettable practices referred to by the author.[15] These practices did not compromise the effectiveness of the coronial investigation or the coronial outcomes, but rather were revealed through the thoroughness and effectiveness of the coronial investigation. It is because of the public nature of the coronial investigation that these practices are publicly known, and it is thanks to the coronial recommendations and other reviews that systems are now in place to minimize the risk of them occurring again. In relation to the author's assertion that Homicide Squad officers covertly recorded meetings with the author's family, the State party notes that the State of Victoria has apologised to the author for this and acknowledges that this practice was unnecessary and would have been distressing to the family. The State party notes, however, that there is no evidence to indicate that the recordings interfered with the investigation.

4.15 The State party notes that, following the recommendations made by the coroner in the inquest into the author's son's death, and the recommendations made in the Office of Police Integrity's overall review of the investigative process following a death associated with police contact, several changes to enhance the process and procedures for investigating deaths involving police contact were made in Victoria, including within the Coroners Court, Victoria Police and the Ethical Standards Department and through the establishment of the Independent Broad-based Anti-corruption Commission.

4.16 As concerns the author's claims under article 14 (1), the State party notes the Committee's jurisprudence that the concept of a suit at law is based on the nature of the right in question rather than on the status of the one of the parties.[16] It argues that the investigation did not relate to a particular right, and that the coroner was not engaged in a determination of rights and obligations in a suit at law. The coroner was only required to investigate the circumstances of the author's son's death and make a determination as to what happened. The State party submits that the investigation does not constitute a suit at law, and therefore that article 14 (1) does not apply to the communication. If the Committee considers that article 14 applies to the coronial investigation, the State party submits that it was fair, public and independent.

4.17 As concerns the author's claims under article 2 of the Covenant, the State party argues that the article does not establish independent rights. It submits that the coronial investigation into the author's son's death did not breach articles 6 (1) or 14. It submits that, as there has been no violation of any substantive right, it is not under any obligation to provide an effective remedy for such a breach.

Author's comments on the State party's observations on admissibility and the merits

5.1 On 10 March 2015, the author submitted her comments on the State party's observations. She maintains that the communication is admissible. She notes that the State party submits that she could appeal the inquest findings. She argues that this avenue is not open to her, as she cannot raise the issue of whether there was a procedural breach of the right to life as a point of law in an application for judicial review. She submits that it is not possible under judicial review to seek a remedy regarding the nature of the investigation itself. Judicial review on a question of law is available when a coroner has failed to exercise his or her jurisdiction to investigate a death and issue the findings required under the Coroners Act 2008. It is not available in circumstances where the very nature of the investigation — namely an investigation conducted by police without sufficient independence — is impugned, rather than the exercise of the coroner's power on the basis of that investigation. The author notes that the coroner herself stated during the inquest that she would not examine the model of how deaths associated with police conduct are

[15] The State party notes that these, for example, included the covert recording of discussions with the author, the one-hour delay in notifying the Homicide Squad, the police officer left unsupervised at the scene, the delay in conducting gunshot residue testing and the delay in conducting alcohol and drug testing.

[16] The State party refers to *Zundel v. Canada* (CCPR/C/89/D/1341/2005), para. 6.8.

investigated or the fact that the inquest brief had been prepared by Victoria Police. Accordingly, judicial review is unavailable on this issue.

5.2 The author further submits that the specific remedy of judicial review identified by the State party are unavailable and would not have a reasonable prospect of success. She argues that there is no suggestion that the coroner issued a finding that was not open on the evidence. The coroner did not examine the model of investigation, and it is that model that forms the basis of the author's submission that her and her son's rights have been breached. She cannot seek judicial review of a finding that does not exist. Although the coroner did make comments regarding the competency, adequacy and impartiality of the manner in which evidence was obtained and treated, this did not relate to the fundamental procedural obligations of the State party pursuant to the right to life. The grounds for judicial review identified by the State party would be more relevant if the findings being challenged related to the cause and circumstances of the death, and not to the procedural aspects of the investigation into that death. The author further argues that a failure to accord natural justice might arise where a family is not provided with an opportunity to make submissions on a possible adverse finding concerning their interests during a coronial investigation, or where the coroner is accused of bias. These grounds are irrelevant in the case at hand, as the complaint concerns the claim that the investigation upon which the coroner relied was not sufficiently independent of Victoria Police to satisfy the procedural obligations imposed under article 6 (1) of the Covenant. The author submits that there are no grounds to seek judicial review on the basis of the insufficiency of the inquiry. She argues that the grounds for review would only be relevant if the coroner failed to refer to evidence central to the investigation or made findings overwhelmingly contrary to the principal findings of fact, or if the findings were tainted by legal error.

5.3 The author maintains that a new inquest would not be an effective remedy. The coroner would still rely on Victoria Police to gather evidence and conduct investigations. Irrespective of her level of oversight, the coroner would still rely on an investigation that was not sufficiently independent. Additionally, a breach of the procedural obligations associated with the right to life has already occurred and cannot be remedied by another investigation. For the same reasons, even if the Supreme Court of Victoria could quash the previous inquest and order that a new one be conducted, it would still not correct the deficiencies of the original investigation.

5.4 The author notes that, while she may seek damages for wrongful death or common-law negligence, this action would relate to a substantive breach of the right to life, rather than the procedural breaches that are the subject of the communication. She further argues that any action to commence a private prosecution would suffer the same deficiency. There is no avenue for her to commence a private prosecution to redress the procedural deficiencies of the investigation. In any event, the Director of Public Prosecutions has an effective veto over any private investigation by virtue of section 22 (1) (b) (ii) of the Public Prosecutions Act 1994. Furthermore, any private prosecution would relate to criminal charges against specified persons, which are outside the scope of the author's communication to the Committee.

5.5 The author notes the State party's submission that she has failed to exhaust domestic remedies by not submitting a complaint to the Independent Broad-based Anti-corruption Commission. She submits that this avenue has been explored, as she requested the Commission's predecessor organization, the Office of Police Integrity, to assume the conduct of the investigation. This request was refused. She notes that section 4 of the schedule to the Independent Broad-based Anti-corruption Commission Act states that all debts, liabilities and obligations of the Office of Police Integrity became those of Commission when the former body was abolished, and any reference to the Office of Police Integrity in any legislation is taken to be a reference to the Independent Broad-based Anti-corruption Commission. In those circumstances, considering that the Commission completely succeeded the Office of Police Integrity, the author submits that she has explored this avenue. She further submits that if the Commission were to conduct an investigation into any police personnel misconduct, the remedies available to her would not be effective. While the Commission may recommend or initiate criminal proceedings in its own right, it may only do so in relation to a potential criminal offence. This would not

remedy any breach of the State's procedural obligations regarding the adequacy of the investigation.

5.6 The author notes that in its observations, the State party refers to a number of changes that are said to have been made to the coronial system and investigative processes since the death of her son. She submits that these changes are not relevant to the question of whether the State party has breached article 6 (1) in relation to the investigation of her son's death because the changes were introduced after the investigation into her son's death was completed.

5.7 The author reiterates her initial submission of 3 September 2013 and maintains that, by failing to ensure a hierarchically, institutionally and practically independent investigation, the State party is in violation of article 6 (1) of the Covenant, and that by failing to ensure an effective remedy for the breach of her son's right to have his death investigated in accordance with procedural requirements, the State party is in violation of article 2 (3) of the Covenant.

State party's additional observations

6. On 26 October 2015, the State party submitted its observations on the author's comments. It notes the author's argument that any judicial review proceedings brought by her would need to relate to the coroner's inquiry, and that she would not be able to pursue judicial review in relation to the nature of the police investigation itself. The State party refers to its observations of 17 November 2014 and it notes that the coroner considered the alleged deficiencies in the way the police investigation was conducted. The coroner found that any deficiency, while regrettable, did not compromise the overall effectiveness of the coronial investigation or outcomes. It submits that if the author considers that the alleged deficiencies did, in fact, compromise the coronial investigation or outcomes, she may challenge the coroner's findings on that subject, and thus the nature of the police investigation. As such, the option of judicial review is available to the author.

Issues and proceedings before the Committee

Consideration of admissibility

7.1 Before considering any claim contained in a communication, the Committee must decide, in accordance with rule 93 of its rules of procedure, whether it is admissible under the Optional Protocol.

7.2 The Committee has ascertained, as required under article 5 (2) (a) of the Optional Protocol, that the same matter is not being examined under another procedure of international investigation or settlement.

7.3 The Committee notes the author's claim that the current model in Victoria for the investigation of deaths associated with police contact is inconsistent with the State party's obligations under the Covenant. It notes her claim that the State party failed to ensure an effective and independent investigation into the death of her son, in violation of her and her son's rights under article 6 (1), read alone and in conjunction with article 2 (3), and in violation of her rights under article 14, of the Covenant. It also notes her claim that there were deficiencies in the investigation conducted by Victoria Police and her submission that legitimate doubts can be raised as to the overall integrity of the investigative process.

7.4 The Committee notes the State party's submission that the communication should be considered inadmissible on the grounds of non-exhaustion of domestic remedies.

7.5 The Committee notes the State party's submission that the author could challenge the coroner's findings before the Supreme Court of Victoria and seek a new inquest on the grounds that the findings were not open on the evidence, that there was a failure to accord natural justice, or that there was an insufficient inquiry. The Committee also notes the State party's submission that the author could file a complaint with the Independent Broad-based Anti-corruption Commission.

7.6 The Committee notes the author's argument that an application for judicial review is not possible in her case, as she could not seek a remedy regarding the nature of the

investigation itself in an application for judicial review. It notes her argument that the grounds for judicial review listed by the State party are irrelevant in her case, as her complaint concerns the claim that the investigation upon which the coroner relied was not sufficiently independent of Victoria Police to satisfy the procedural obligations imposed under article 6 (1) of the Covenant. The Committee further notes the author's argument that a new inquest would not be an effective remedy, as in the event of a new inquest, the coroner would still rely on Victoria Police to gather evidence and conduct investigations. It further notes her argument that she has explored the avenue of recourse to the Independent Broad-based Anti-corruption Commission, as her request for the Commission's predecessor organization, the Office of Police Integrity, to take over the investigation was denied.

7.7 The Committee further notes that the State party disputes the author's argument that a new inquest would not offer a reasonable prospect of success, as the coroner has extensive powers of investigation, which are not limited to relying on any existing evidence, and as the Coroners Act 2008 enables the court to refer matters to prosecutorial bodies to consider whether criminal proceedings should be instituted. It further notes the State party's argument that if the author considers that the deficiencies she has referred to compromised the coronial investigation or outcomes, she may challenge the coroner's findings on that subject, and thus the nature of the police investigation, by way of judicial review. It further notes the State party's argument that, as the author appears to be of the view that the coroner failed to deal with the competency, adequacy and impartiality of the police investigation, she may pursue a claim on the grounds that there has been an insufficient inquiry before the Supreme Court. The Committee recalls that international standards for such an investigation are set out in the Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016). Paragraph 8 (c) of the Protocol describes the duty to investigate as an essential part of upholding the right to life, paragraph 28 sets out the requirement of impartiality and independence and paragraph 35 describes the role of the family.

7.8 The Committee recalls its jurisprudence that, although there is no obligation to exhaust domestic remedies if they have no chance of being successful, authors of communications must exercise due diligence in the pursuit of available remedies, and that mere doubts or assumptions about their effectiveness do not absolve the authors from exhausting them.[17] The Committee observes that, in the present case, the option of an application for judicial review of the coronial findings was open to the author. It further notes that the author has referred to a number of deficiencies that she contends raise doubts as to the overall integrity of the investigative process. It notes the State party's argument that if the author considered that these deficiencies compromised the coronial investigation or outcomes, she could have challenged the findings on that subject, and thus the nature of the police investigation, by way of judicial review. The Committee notes that the author has not, however, raised these deficiencies in an application for judicial review, nor has she raised any other aspect related to the police investigation or the coroner's inquest before the domestic authorities. The Committee recalls that it can examine claims relating to the lack of independence of the institutions and proceedings surrounding a criminal investigation and identify legislation or practices that are inconsistent with the rights protected under the Covenant. However, claims regarding the lack of independence of a police investigation formulated in general terms and not based on concrete facts and evidence challenged before the domestic authorities have been found to be inadmissible.[18] In these circumstances, as the author has not raised her claims of deficiencies in the investigation before the domestic authorities, and taking into account the State party's submission that a potential new inquest following an application for judicial review would have been an effective remedy considering the fact that a coroner has extensive powers of investigation and the power to refer matters to prosecutorial bodies, the Committee is of the view that the author has failed to exhaust available domestic remedies. The Committee therefore considers that the communication is inadmissible pursuant to article 5 (2) (b) of the Optional Protocol.

[17] See, inter alia, *V.S. v. New Zealand* (CCPR/C/115/D/2072/2011), para. 6.3; *García Perea v. Spain* (CCPR/C/95/D/1511/2006), para. 6.2; and *Zsolt Vargay v. Canada* (CCPR/C/96/D/1639/2007), para. 7.3.

[18] See *Hickey v. Australia* (CCPR/C/111/D/1995/2010), para. 8.4.

8. The Committee therefore decides:

(a) That the communication is inadmissible under article 5 (2) (b) of the Optional Protocol;

(b) That the present decision shall be transmitted to the State party and to the author.